

Patient Stick

BAH-00637118 IP5-00176243
 Baby M SAI VIDHATHRI
 29-01-2022 4 Y 5 M 12 D (F)
 Dr. NAMRATA KAMALAKAR RAO

Rainbow
Children's
Hospital
 It takes a lot to treat the little.

BirthRight
 BY RAINBOW HOSPITALS
 Your Right to a Safe Delivery

SURGERY DETAILS

Date : 11/07/20

Patient Name: M Sai Vidhathi Date of Birth: 29-01-2022 Age: 4Y

Gender: Female Ward: P.O.T UHID No: BAH-00637118

Date of Surgery: 11/07/20 ☐ OT -1 ☐ OT -2 ☒ OT -3 ☐ OT -4 ☐ OBG OT-1 ☐ OBG OT-2

Name of the Surgery : COMPREHENSIVE ORAL REHAB (D) GA

Time in : 9:15 Am

Time Out : 10:30 Am

	NAME	AMOUNT
1. Surgeon	DR NAMRATA R	DP- I
2. Anaesthetist	A. Tejaswini	
3. Assistant Surgeon		
4. OT Technician	Kubera	
5. Circulating Nurse	Bibbi	
6. Assistant Nurse	Diya	

Special Equipment: ☐ Laparoscopy

☐ Broncoscope

☐ Harmonic

☐ Morcelator

☐ C-ARM

☐ Cystoscopy

☐ Versa Point

☐ Liver Cusa

☐ Neuro Cusa

☐ Others

COLLECT 2000/- TOWARDS CROWN

Signature of the Surgeon

Signature of Circulating Nurse

Order No: 9697675

Order by: Diya

6710

Shanthi,
KGS

Dental

CONSUMABLES OF OT

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Circulating staff : Technician : Date : 11/7 Time : 9 AM

Anaesthesia Disposables		Qty		Surgical Disposables		Qty		Disposables (Baby Side)		Qty	
Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used	Issued	Used
ET tube 4.4.5.15	14/1	01		Major Pack Surgical pack 1	1			Inj Vit.K			
LMA	01	—		Sutures				Cord Clamp			
ECG leads : A (P) N	05	3						Suction Catheter			
HME filter : A (P) N	01	1						Feeding Tube			
Syringes : 10 cc	10	10						Vacuum Suction Set			
05 cc	15	10		Gloves 6.6.2.2.2.2.2.2	—			Surgical Gloves			
02 cc	15	10		PF 6.6.2.2.2.2.2.2	14/1			Gauze Pack			
01 cc	10	0						Syringe 1ml / 2ml			
Cautery plate : A (P) N	01	—		Surgical blade				Surgical Blade # 20			
IV set	01	1		NG tube				Koochies (S)			
RL	01	1		Cautery pencil				NS 500ml	2	1	
NS : 10ml / 100ml / 500ml / 1000ml	4/1	1		Koochies				Transfused	1	1	
Milky spike	01	1		Ointments				1000.5K	2	2	14/1
02 Mask	01	—		Suction Catheter				Roll Suture	1	1	
Fentanyl	01	1		Cap, Mask				26 Needle	1	1	
Morphine				Gauze Pack	(N)	3	3	Lox 2 Adline	1	1	
Ketamine				Mop Pack							
Propofol	03	2		Steristrip							
Rocuronium	01	1		Underpad		1	1				
Glycopyrolate	01	1		Draw sheet		1	1				
Myopyrolate Neo	01	02		Abgel							
Ondansetron	01	1		Foleys catheter				Adrenaline 1000mg 14/1			
Pencan 25g/ Spinal Needle 22				Urobag				dox 1 and 2.4.4.4.4.4.4.4 14/1			
Bupivacaine 0.25%	01	—		Chest Drainage Catheter				Mildax + Ephedrine 14/1			
Bupivacaine 0.25% (Heavy)				Romodrain bag				NG + Suction all	—		
Antibiotics In pan	01	1		Bandage				Q sel, Splint (14/1)	—		
				Tegaderm				Dexat Dexmed 14/1	01		
Suppositories				Ioban				Tramexon	01	—	
Anamol : 80mg / 250mg / 170 mg				Double J Stent				Gauze gloves 44402			
Supridol : 100mg				Vacuum Suction set		1	1	5000 + pmol 14/1			
Justin : 12.5 mg 25mg 100mg	14/1	1		Plastic Bed Sheet		1	1	Transfused	1	1	
Tab. Misoprost : 200mg				Betadine Solution							
Vacuum set	01	1		Microshield		1	1				
Swabs 10 + 100 cm	14/1	1		Cotton Balls		1	1				
DA (D 11)	14/1	—		Latex Gloves		100	100				
N.A (20, 22)	14/1	—		Ramdone Scrub							
IV Amel (5000)	14/1	—		Saral							

Surgeon

Anaesthesiologist

Nurse

OT Technician

Order No. : 9697706

Ordered by : [Signature]

Doc. No. : RCH / FRM / GENERAL / 125

ADMISSION SHEET



Registration Details :

Admission No : IP5-00176243 Admit Date : 11-Jul-2026 Admit Time : 07:21 AM UHID : BAH-00637118

Patient Details :

Patient Name	: Baby M SAI VIDHATHRI	Age	: 4 Y 5 M 12 D
Guardian	: Mr M.RAVITEJA	DOB	: 29-01-2022
Gender	: Female	Religion	:
Occupation	:	Martial Status	: Single
Address (H)	: #FLAT NO 501, R V R -2 NILAYAM, BAPU GHAT ROAD Attapur Hyderabad Telangana INDIA 500048	Phone No	: 8019777994/ 9381737540
		E-mail	: nomailid@gmail.com

Admission Details :

Bed Type	: DAY CARE	Bed No	: PRE OP 401	Ward Name	: 4F-OT COMPLEX
Room No	: PRE OP 401	Admission Type	: First Visit		

Contact Details :

Name	: Mr M.RAVITEJA	Relationship	: Father
Contact Address	: #FLAT NO 501, R V R -2 NILAYAM, BAPU GHAT ROAD Attapur Hyderabad Telangana INDIA 500048	Phone No	: 8019777994 / 9381737540


Signature

Doctor Details :

Doctor Name	: Dr. NAMRATA KAMALAKAR RAO KOTHAPALLI	Specialisation	: DENTAL
Referral Doctor	: Self	Phone No	:
Co-Consultant	:		

Payment Details :

Payment Mode	: Cash	Deposit Amount	: 0.00
		Payor Name	: SELFPAY

ACTIVITY RECORD FOR BILLING

Name : _____

UHID No. : _____ I _____ Itant: _____ Dept : _____

Date of Admission: _____ Date of Discharge : _____ Time: _____

Room / Bed No : _____ Suggested Billable bed type : _____

BAH-00637118 IP5-00176243
Baby M SAI VIDHATHRI
29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO


WARD TRANSFERS

Date	Time	From	To	Signature of Nurse
11/7/26	7:45Am	ER	OT	Annab
11/7/26	11:53Am	OT	billing	Quel

Cross Consultation Visit

	Doctors Name	Date	Order No.	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

INVESTIGATIONS

[illegible]

MEDICAL EQUIPMENT (WARD & ICU)

[illegible]

PROCEDURE

Date	Procedure	Quantity	Order No.	Signature
11/7/26	IV placement PAE op basis	(1)	7406	Amul

ANY OTHER INFORMATION

.....

.....

.....

.....

.....

.....

Date :

Time :

Prepared By :

Staff Nurse	Shift / Ward	Billing Assistant	Billing Supervisor



INFORMED CONSENT FOR SURGERY / PROCEDURE

Authorization By: ☐ Patient ☒ Patient Attendant

I, the undersigned do hereby agree to undergo the following surgery(s), Procedure(s) on patient / myself at Rainbow Children's Hospital. (Avoid technical terms and leave no blank space)

1. COMPREHENSIVE ORAL REHAB (I) G.A.

2. _____

I acknowledge the following:

- I have been made aware of the benefits and reasons of the surgery / procedure as indicated by the clinical observations and / or diagnostics performed.
- The benefits and risks of this surgery / procedure have been explained to me. I have also been told about the alternatives available for this surgery / procedure including the advantages and disadvantages of the alternatives.

Benefits of the Surgery(s) / Procedure(s)	Alternatives of the Surgery(s) / Procedure(s)
<u>RELIEF OF PAIN AND INFECTION</u>	

- As with any procedure, I am aware that risks such as blood loss, infection, cardiac arrest, anesthetic allergic reactions, paralysis, Deep Vein thrombosis (DVT), Pulmonary thromboembolism (PTE) etc may arise necessitating attention. Therefore, in addition to consenting to the performance of the above-mentioned surgery/procedure(s), I also consent and authorize the rendering of such other care and treatment as patient/my surgeon or his / her designee reasonably believes necessary should one or more of these and or other unforeseeable events occur.

Apart from the listed above, I have also been explained about the possible complications of the surgery / procedure are as follows:

- NO COMPLICATIONS.
-

- I authorize Dr. _____ and his / her team to perform the procedural sedation upon the patient / myself.
- I recognize that the practice of medicine is as much an art as a science and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcomes.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: _____

Name: M. Ravi

Relationship with patient: Father

Date & Time: 11/07/26 9:08 AM

Witness:

Signature: _____

Name: Mother

Date & Time: 11/07/2026 @ 9 am

Doctor (who is taking consent):

Signature: _____ Name: DR NAMRATA

Date: 11/07/26 Time: 9:04 AM

శస్త్రచికిత్స / ప్రాసీజర్ కు అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

నేను, దిగువ సంతకం చేసిన వ్యక్తి, రోగి/నా పైన రైన్బో చిల్డ్రన్ హాస్పిటల్లో చేయబడబోయే క్రింది శస్త్రచికిత్స(లు) / ప్రాసీజర్(లు) చేయడానికి అంగీకరిస్తున్నాను. (టెక్నికల్ పదాలు వాడవద్దు మరియు భాళ స్థలం వదిలివేయకండి)

1

2

నేను కింది విషయాలను అంగీకరిస్తున్నాను:

- క్లినికల్ పరిశీలనలు మరియు/లేదా చేసిన పరీక్షల ఆధారంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ అవసరం మరియు ప్రయోజనాల గురించి నాకు వివరించబడింది.
- ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు సంబంధించిన ప్రయోజనాలు మరియు ప్రమాదాలు నాకు స్పష్టంగా వివరించబడ్డాయి.
ఈ శస్త్రచికిత్స / ప్రాసీజర్ కు ఉన్న ప్రత్యామ్నాయాల గురించి, వాటి ప్రయోజనాలు మరియు నష్టాలు నాకు వివరించబడ్డాయి.

శస్త్రచికిత్స / ప్రాసీజర్ ప్రయోజనాలు:	శస్త్రచికిత్స / ప్రాసీజర్ ప్రత్యామ్నాయాలు

- ఏదైనా శస్త్రచికిత్స / ప్రాసీజర్ లాగానే, రక్తస్రావం, ఇన్ఫెక్షన్, గుండె ఆగిపోవడం, అనస్థీసియా వల్ల అలెర్జిక్, పక్షవాతం, డీప్ వెయిన్ థ్రాంబోసిస్ (DVT), పల్మనరీ థ్రోంబోఎంబోలిజం (PTE) వంటి ప్రమాదాలు సంభవించే అవకాశం ఉందని నాకు తెలుసు.
అందువల్ల, పై శస్త్రచికిత్స / ప్రాసీజర్ నేను ఇచ్చే అనుమతితో పాటు, పై పేర్కొన్న సమస్యలు లేదా అనుకోని పరిస్థితులు ఏర్పడినప్పుడు, రోగి/నా కోసం అవసరమని వైద్యుడు భావించే ఇతర చికిత్సలను చేయడానికి కూడా నేను అనుమతిస్తున్నాను.

అదనంగా, ఈ శస్త్రచికిత్స / ప్రాసీజర్ వల్ల సంభవించగల ఇతర సమస్యలు కూడా నాకు వివరించబడ్డాయి:

a.	
b.	

- డాక్టర్ _____ గారిని మరియు వారి బృందాన్ని, రోగి/నాపై ఈ శస్త్రచికిత్స / ప్రాసీజర్ ను చేయడానికి నేను అనుమతిస్తున్నాను.
- వైద్యం ఒక శాస్త్రం మాత్రమే కాక కళ కూడా అని నేను అంగీకరిస్తున్నాను. అందువల్ల, శస్త్రచికిత్స / ప్రాసీజర్ ఫలితం గానీ, విజయావకాశం గానీ ఏ గ్యారంటీ ఇవ్వలేమని నేను అర్థం చేసుకున్నాను.
- పై వివరాలన్నీ నాకు పూర్తిగా అర్థమయ్యాయి. నాకు సందేహాలు అడగడానికి అవకాశం ఇచ్చారు, మరియు అవన్నీ నాకు అర్థమయ్యే భాష సమాధానం ఇచ్చారు.
ఈ అనుమతిని నేను పూర్తి జ్ఞానస్థితిలో, స్వచ్ఛందంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

SURGICAL SAFETY CHECKLIST

Surgeon : Dr. Namrata
Asst. Surgeon :
Anaesthetist : Dr. Tejashwini
Scrub Nurse : Shruti

BABY M SAI VIDHATHRI
29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO
Date : 11/07/22 In-time : 9:15 AM Out-time : 10:30 AM

Age : 44 Gender : F
Surgery Name : Dental



Before Induction of Anaesthesia >>

Before Skin Incision >>

Before Patient Leaves Operating Room

SIGN IN	Time: <u>9:09 AM</u>
Patient Has Confirmed	
Identity	☒ Yes ☐ No
Site	☐ Yes ☒ No
Procedure	☒ Yes ☐ No
Consent	☒ Yes ☐ No
Site Marked	☐ Yes ☐ No ☒ NA
Anaesthesia Safety Check Completed	☒ Yes ☐ No
Pulse Oximeter on Patient & Functioning	☒ Yes ☐ No
Does Patient have a:	
Known Allergy?	☐ Yes ☒ No
Difficult Airway / Aspiration Risk?	
Yes, & Equipment / Assistance Available	☒ Yes ☐ No
Risk of > 500ml Blood Loss (7ml/kg In Children)?	
Yes, and Adequate Intravenous Access and Fluids Planned	☒ Yes ☐ No ☐ NA
Blood Units Reserved	☐ Yes ☒ No ☐ NA
Has Antibiotic Prophylaxis been given within the last 60 minutes?	☒ Yes ☐ No ☐ NA
Signature : <u>[Signature]</u>	
Name : <u>Dr. Shruti</u>	

TIME OUT	Time: <u>9:29 AM</u>
Confirm all team members have introduced themselves by Name and Role	☒ Yes ☐ No
Surgeon, Anaesthesia Professional and Nurse Verbally Confirm	
Correct Patient (Check ID Band)	☒ Yes ☐ No
Correct Site	☒ Yes ☐ No
Correct Procedure	☒ Yes ☐ No
Anticipated Critical Events	
Surgeon Reviews:	
What are the Critical or Unexpected Steps, Operative Duration, Anticipated Blood Loss?	<u>Nothing less than 200ml</u> ☐ Yes ☒ No ☐ NA
Anaesthesia Team Reviews:	
Are There Any Patient-specific Concerns?	☐ Yes ☒ No ☐ NA
Nursing Team Reviews:	
Has Sterility (including indicator results) Been Confirmed? are there Equipment issues or any Concerns?	☒ Yes ☐ No ☐ NA
Is Essential Imaging Displayed?	☐ Yes ☒ No ☐ NA
Power Supply, Earthing, Power Backup and functioning of equipment checked.	☒ Yes ☐ No
Signature : <u>[Signature]</u>	
Name : <u>Dr. Namrata</u>	

SIGN OUT	Time: <u>10:00 AM</u>
Nurse Verbally Confirms with the Team:	
The Name of the Procedure Recorded	☒ Yes ☐ No
That Instrument, Sponge and Needle Counts are Correct (or Not Applicable)	☒ Yes ☐ No ☐ NA
The Specimen is Labelled (including patient name)	☐ Yes ☒ No ☐ NA
Whether there are any Equipment Problems to be addressed	☐ Yes ☒ No ☐ NA
To Surgeon, Anaesthetist and Nurse:	
What are the key concerns for recovery and management of this patient?	☐ Yes ☒ No
Signature : <u>Namrata</u>	
Name : <u>DR. NAMRATA K.</u>	

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29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO



Patient Sticker

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BirthRight
BY RAINBOW HOSPITALS
Your Right to a Safe Delivery

BUNDLE CARE CHECKLIST TO PREVENT SURGICAL SITE INFECTION (SSI)

To Be Filled In By Assigned Nurse :

Date : 11/07/20

Department : P.O.T. Duration of Procedure : 1 hr

Name of Surgeon : Dr. Namrata Date of Admission : 11/07/20

Bundle Care Criteria : (Tick (✓) if done)

		Staff Signature
1.	Antibiotic given prior to surgery ? ☐ Yes ☒ No ☐ Single Dose Antibiotic or Long Antibiotic Regime Antibiotic administered within 60 minutes prior to incision ? ☐ Yes ☒ No Name of the Antibiotic :	Bicalai
2.	Hair Removal ☐ Yes ☒ No if Yes : Surgical Clipper Department where Hair Removed : ☐ Ward ☐ Operating Room ☐ Other : Skin preparation done (cleanse surgical area with antiseptic agent)? ☐ Yes ☒ No	Bicalai
3.	Patient's body temperature immediately post operation (Recovery Room) 36 °C ☐ Oral Or ☒ Axilla (Goal : 36-37 °C)	Bicalai
4.	Name of doctor or staff administering the antibiotic : Dr. Namrata Date & Time of antibiotic administration : 11/07/20 at Date & Time procedure started : 11/07/20 at	Bicalai

- Ensure form is filled in completely by assigned staff whenever patient had surgery
- If any bundle care criteria has not been observed or unmet, assigned staff must inform infection control nurse for management
- All forms (Bundle care and when required SSI form) are completed properly
- Forms must always be kept in Infection Control folder in respective department

Docu. No. : RCHBH/ FRM / CLINICAL / 038

BAH-00637118 IP5-00176243
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29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO



Patient Sticke

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BY RAINBOW HOSPITALS
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OPERATION THEATER NOTES

Patient's Name : Age : Gender : ☐ Male ☐ Female

UHID No. : Weight : Height :

Surgeon :		Asst. Surgeon :	
Anesthetist :	OT Nurse:	OT Technician:	
Pre-Operative Diagnosis:			
Surgical Procedure : COMPREHENSIVE ORAL REHAB (↓) GIA .			
Indications for Surgery : DENTAL CARIES .			
Date :	Start Time : 9:35AM	End Time : 10:20A	
Pre Operative Preparations:			
Post Operative Diagnosis:			
Peri-Operative Complications:			
Operation Notes: GIA (↓) NASAL INTUBATION .			
1. PULPECTOMY DONE ON 53, 62 .			
2. EXTRACTION DONE OF 54, 51, 52, 61, 64 .			
3. GIC RESTORATION DONE ON 53, 62 .			
4. STAINLESS STEEL CROWN ON 84 .			
SOFT FOOD FOR 3 DAYS			
GENTLE BRUSHING FOR 3 DAYS			
REVIEW AFTER 3 DAYS .			

R_x

Symp. IBUGESIC (5ml) x 3 days
(1 — 1 — 1)

Amount of Blood Loss:

Blood Transfused (in ML)

Name and Number of Surgical Specimen sent for examination:

Peri-Operative Complications:

Name of the Surgeon: DR NAMRATA K.

Signature of the Surgeon: Namrata

Date & Time: 11/07/26 10:16 AM

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29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO

Patient Sticker




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Your Right to a Safe Delivery

POST-SURGICAL CARE PLAN FORM

Procedure Done: PULP THERAPY, EXTRACTIONS, CROWN

Post-Surgical Diagnosis:

Post-Operative Monitoring Parameters /Frequency:

Wound Care:

BLEEDING EVERY 15 MINS

Drain /Special Lines/Catheters:

Special Patient Positioning and Requirements:

Nutritional Instructions:

When to Start Mobilization:

Special Referrals:

The new order for all required medications documented in the doctor order/medication sheet:

☐ Yes ☐ No

Any Other Post-Operative Care Needed including Required Follow Up

Namrata
Treating Surgeon
(Signature & Stamp)

Date: 11/07/26 Time: 10:16 AM

Note: Plan of care will be readjusted if necessary.



DRUG CHART

Date of Admission: 11/7/22 Drug Allergies: ☒ Not known any Drug Allergies

FOR THE SAFETY OF THE PATIENT

- GENERAL** - Ensure that all patient details are entered above. ONLY A DOCTOR SHALL WRITE MEDICATION ORDERS.
- DOCTOR** - Please use only approved abbreviations (refer to Hospital's approved list of abbreviations).
 - Use approved pharmaceutical names, BLOCK LETTERS, metric dosage. English instructions.
 - Any changes in drug therapy must be ordered by a NEW PRESCRIPTION. Do not alter existing instructions.
 - Discontinue a drug by drawing a line **I** through it and a similar line through subsequent recording panels.
 - The date and time of stopping the drug along with the doctors name and sign must be mentioned.
 - Only one chart should be in use at any one time. When the chart is full, a new supplement can be kept within this drug sheet folder.
- NURSES** - Nurses must follow strictly the FIVE RIGHTS before administration of medication.
 1) Right Patient 2) Right Drug 3) Right Dosage 4) Right Route 5) Right Time
 - AVOID TAKING VERBAL ORDERS. NO VERBAL ORDERS FOR HIGH RISK/HIGH ALERT MEDICINES
 (EXCEPT FIRST DOSE OF EPINEPHRINE DURING CPR). Follow Hospitals's Verbal Order Policy.

SOS / PRN (As Required Medication)

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

DRUG :				Date Time															
Dose	Route	Frequency	Start Date																
Doctor's Signature		Valid Period	Pharm.																
Additional Instructions:																			

BAH-00637118 IP5-00176243
 Baby M SAI VIDHATHRI
 29-01-2022 4 Y 5 M 12 D (F)
 Dr. NAMRATA KAMALAKAR RAO

REGULAR PRESCRIPTIONS

Weight. 15.4 kg Ward.



DRL				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				
DRUG :				Date Time
Dose	Route	Frequency	Start Date	
Name & Signature of the Doctor Starting the Drugs:				
Additional Instructions:				
Daily Doctor's Endorsement by a Sign				

Weight. 15.419 Ward.

[illegible]

VARIABLE DOSE		Date Time								
				Nurse Sig.		Nurse Sig.		Nurse Sig.		Nurse Sig.
DRUG :			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Route	Start Date		Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Name & Signature of the Doctor			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	
Additional Instructions:			Dose		Dose		Dose		Dose	
			Dr. Sign.		Dr. Sign.		Dr. Sign.		Dr. Sign.	

STAT / ONCE ONLY DRUGS[illegible]

Weight. 15.4kg Ward.

[illegible]

BAH-00637118
Baby M SAI VIDHATHRI
29-01-2022 4 Y 6 M 12 D
Dr. NAMRATA KAMALAKAR RAO (F)

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MEDICATION RECONCILIATION FORM

Drug Allergies:

☒ Not known any Drug Allergies

Medication Reconciliation will be done at the time of admission and also whenever there is change in the treating team or shifting from one unit to another unit.

(Example: at the time of admission shifting from ICU to Ward, or Ward to ICUs)

Shifting From: ICU

Shifted to: ICU

S.No	MEDICATION NAME (GENERIC NAME CAPITAL LETTERS)	DOSE (mg, mcg)	ROUTE (PO, NG, SC, IV)	FREQUENCY	LAST DOSE Date / Time	ON ADMISSION / SHIFTING
1						☐ C ☐ DC
2						☐ C ☐ DC
3						☐ C ☐ DC
4						☐ C ☐ DC
5						☐ C ☐ DC
6						☐ C ☐ DC
7						☐ C ☐ DC
8						☐ C ☐ DC
9						☐ C ☐ DC
10						☐ C ☐ DC

* C - Continue, DC - Discontinue

MEDICATION HISTORY RECORDED / VERIFIED BY

Doctor Name & Signature : Dr. Nishu

Date & Time : 11/7/26 7:15 AM

Nurse Name & Signature : Annaub

Date & Time : 11/7/26 7:30 AM

Patient Sticker

PROGRESS NOTES AND DOCTOR'S ORDER

[illegible]

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RESULT SHEET

Date						
Time						
Hb						
PCV						
RBC						
WBC						
N/L						
Platelets						
CRP						
ESR						
PCT						
RBS						
Na						
K						
Cl						
Ca/Mg						
Phosphate						
Urea						
Creatinine						
ALP						
SGPT						
SGOT						
T.Bill/Conj						
T.Protein						
S.Albumin						
S.Globulin						
A/G Ratio						
Uric Acid						
S.Amylase						
Sr.Lipase						
Blood Lactate						
S.Cholesterol						
PT/INR						
APTT						
CSF Protein / Sugar						
Cells						
N/L						

Date						
Time						
CUE - Alb						
CUE - Sugar						
CUE - Ketones						
CUE - PUS Cells						
CUE - RBC Cells						
CUE						
Stool Pus Cell						
OVA / Cyst						
Occult Blood						

Culture and Sensitivities :

.....

.....

.....

Radiology : USG :

 X-Ray :

 ECHO :

 CT :

 MRI

 Others (ECG, Contrast Studies etc.,) :



FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
Total Intake :						Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :						Total Output :						
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :						Total Output :						
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :						Total Output :						
Total 24 hrs. Intake												
Total 24 hrs. Output												

FLUID CHART

Sheet No. :

1. All measurements in ml.
2. Add up each column separately. Make additions across the page to obtain 24 hrs. total of intake and output.
3. 24 hrs. total to be entered in the kardex in RED.

		Intake				Output					IV Site Thrombo- phlebitis Score	Sign. Nurse
Date	Time	Nature of Fluid	Route			NG	Diarrhoea	Vomit	Drainage	Urine		
			Mouth	I.V	N.G							
	08:00 am											
	09:00 am											
	10:00 am											
	11:00 am											
	12:00 pm											
	01:00 pm											
	Total Intake :					Total Output :						
	02:00 pm											
	03:00 pm											
	04:00 pm											
	05:00 pm											
	06:00 pm											
	07:00 pm											
Total Intake :					Total Output :							
	08:00 pm											
	09:00 pm											
	10:00 pm											
	11:00 pm											
	12:00 am											
	01:00 am											
Total Intake :					Total Output :							
	02:00 am											
	03:00 am											
	04:00 am											
	05:00 am											
	06:00 am											
	07:00 am											
Total Intake :					Total Output :							
Total 24 hrs. Intake												
Total 24 hrs. Output												

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THE HUMPTY DUMPTY SCALE

PARAMETER	CRITERIA	SCORE	DATE	DATE	DATE	DATE	DATE
Age	Less than 3 years old	4					
	3 to less than 7 years old	3	3				
	7 to less than 13 years old	2					
	13 years old and above	1					
Gender	Male	2					
	Female	1	1				
Diagnosis	Neurological Diagnosis	4					
	Alterations in Oxygenation (Respiratory Diagnosis, Dehydration, Anemia, Anorexia Syncope / Dizziness, etc.	3					
	Psych / Behavioral Disorders	2					
	Other Diagnosis	1	1				
Cognitive Impairments	Not Aware of Limitations	3					
	Forget Limitations	2					
	Oriented to own Ability	1	1				
	History of Falls or Infant - Toddler Placed in Bed	4					
Environmental Factors	Patient uses assistive devices or Infant Toddler in Crib or Furniture / Lighting (Tripled Room)	3					
	Patient Placed in Bed	2	2				
	Outpatient Area	1					
Response to Surgery / Sedation Anesthesia	Within 24 hours	3					
	Within 48 hours	2					
	More than 48 hours / None	1	1				
Medication Usage	Sedatives (excluding ICU patients sedated and paralyzed)	3					
	Hypnotics	3					
	Barbiturates	3					
	Phenothiazines	3					
	Antidepressants	3					
	Laxatives / Diuretics	3					
	Narcotics	3					
	One of the Meds listed above	2					
	Other Medications / None	1	1				
TOTAL			10				

Intervention :

-Fall Risk : Low Humpty Dumpty Score = 7-11,

High Risk Humpty Dumpty Score = 12 or above

Bed in low position		yes					
Call device within reach		yes					
Wheels Locked		yes					
Room free of clutter		yes					
Adequate Lighting		yes					
Wheel Chair Support		No					
Other Intervention(s) Specify		no					
Nurse's Name :		Amud					
Signature :		Amud					
Date :		11/04					
Time :		7:20 AM					

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NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Dr. Namrata Department: Date of Admission: 11/7/26

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☒ Not Known If Yes Specify:					
	<u>Dental Surg</u>							
BACKGROUND	Area	<u>ER</u>						
	Shift Time	<u>7:45h</u>						
	Medical Condition (Any special condition to be noted):	<u>NO</u>						
ASSESSMENT	Allergy:	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Tubes/Drains/Catheter:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Vital Signs:	Temp: <u>98.1F</u>						
		Res: <u>24b/m</u>						
		SpO ₂ : <u>97%</u>						
		Pulse: <u>116b/m</u>						
		BP: <u>100/52</u>						
		Fall Risk Score: <u>10</u>						
		Pain Score: <u>0/10</u>						
	Recommendations	Safety Needs:	<u>Yes</u>					
Physiotherapy		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Others Specify:		<u>NO</u>						
Special Diet:		☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other Special Orders / Medications:		<u>NO</u>						
	Post Operative Procedure Special Orders:	<u>NO</u>						
	Handed Over By Name :	<u>Annab</u>						
	Signature :	<u>(Signature)</u>						
	Date:	<u>11/7/26</u>						
	Time:	<u>7:45am</u>						
	Taken Over By Name :	<u>(Signature)</u>						
	Signature :	<u>(Signature)</u>						
	Date:	<u>11/7/26</u>						
	Time:	<u>7:45h</u>						

NURSING SHIFT HAND OVER FORM - WARD

Treating Doctor: Department: Date of Admission:

SITUATION	Diagnosis:		Any Infection: ☐ Yes ☐ No ☐ Not Known If Yes Specify:				
BACKGROUND	Area Shift Time						
	Medical Condition (Any special condition to be noted):						
ASSESSMENT	Allergy: Tubes/Drains/Catheter: Vital Signs: Temp: Res: SpO ₂ : Pulse: BP: Fall Risk Score: Pain Score:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Recommendations	Safety Needs: Physiotherapy Others Specify: Special Diet: Other Special Orders / Medications:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Post Operative Procedure Special Orders:						
	Handed Over By Name :						
	Signature :						
	Date:						
	Time:						
	Taken Over By Name :						
	Signature :						
	Date:						
	Time:						

PAIN ASSESSMENT FORM

Date	Time	Pain Score (0/10)	Location	Duration	Acuity	Character	Modifying Factors	Patient / Family Educated	Intervention	Sign
11/7/24	7:18 AM	0/0	NO	☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☒ Yes ☐ No	NO NO	Annab
11/7	10:35 PM	1/10	SS	☐ Continuous ☒ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☒ Dull ☐ Aching ☐ Burning	☒ Increasing ☐ Decreasing	☒ Yes ☐ No	NA	Drif
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		
				☐ Continuous ☐ Intermittent	☐ Acute ☐ Chronic	☐ Sharp ☐ Dull ☐ Aching ☐ Burning	☐ Increasing ☐ Decreasing	☐ Yes ☐ No		

Re-assessment Frequency:

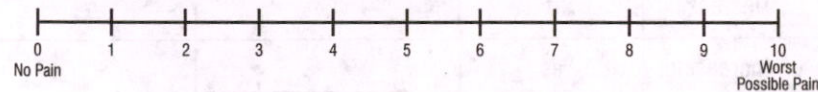
- Every eight hours for all hospitalized patients.
- For post-surgical patients, patients with chronic pain, patient with severe pain:
 - At least every 2 hours for the first 24 hours
 - Then every 4 hours.
 - Prior to pain relieving intervention.
 - Within 30 – 60 minutes after pain relief intervention.

PAIN ASSESSMENT TOOLS

FLACC PAIN ASSESSMENT SCALE (1 Month to 7 Years)

CATEGORY	SCORING		
	0	1	2
Face	No Particular expression or smile	Occasional Grimace or Frown, withdraw, Disoriented	Frequent to constant frown, quivering chin, clenched jaw
Legs	Normal Position or Relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Laying quietly normal position, moves easily	Squirming shifting back and forth, tense	Arched, rigid, or Jerking
Cry	No Cry (Awake or asleep)	Moans or whimpers occasional complaint	Crying steadily, screams of sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort

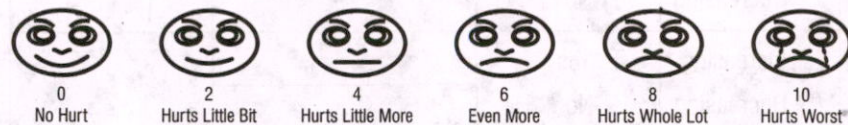
Numerical Pain Scale (Obstetric and Gynecology)



Neonatal Pain, Agitation and Sedation Scale (upto 1 Month)

Assessment Criteria	Sedation		Normal	Pain / Agitation	
	-2	-1	0	1	2
Crying Irritability	No Cry with painful stimuli	Moans or cries minimally with painful stimuli	Appropriate crying Not irritable	Irritable or crying at intervals consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking constantly awake or Arouses minimally / no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	Relaxed Appropriate	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex decreased muscle tone	Relaxed hands and feet Normal Tone	Intermittent clenched toes, fists or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs HR, RR, BP, SaO₂	No variability with stimuli Hypoventilation or apnea	Less than 10% variability from baseline with stimuli	Within baseline or normal for gestational age	Increase 10-20% from baseline SaO ₂ 76-85% with stimulation - quick recovery	Increase greater than 20% from baseline, SaO ₂ less than or equal to 75% with stimulation - slow recovery Out of sync or fighting ventilator

Wong - Baker (Pediatrics) Above 7 Years





BRADEN 'Q' SCALE

					Date :	11/1/20			
					Time :	9:20			
Mobility	1. Completely immobile: Does not make even slight changes in body or extremity position without assistance.	2. Very limited: Makes occasional slight changes in body or extremity position but unable to completely turn self independently.	3. Slightly limited: Makes frequent through slight changes in body or extremity position independently.	4. No limitations: Makes major and frequent changes in position without assistance.	4				
"Activity The degree of physical activity"	1. Bedfast : Confined to bed	2. Chairfast : Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair."	3. Walks occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. All patients too young to ambulate; OR walks frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during walking hours.	4				
Sensory Perception	1. Completely limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli due to diminished level of consciousness or sedation, OR, limited ability to feel pain over most of the body surface.	2. Very limited: responds to only painful stimuli, cannot communicate discomfort except by moaning or restlessness; OR, has sensory impairment that limits the ability to feel pain or discomfort over half of body.	3. Slightly limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned; OR, has some sensory impairment that limits ability to feel pain, or discomfort in one or two extremities.	4. No impairment: Responds to verbal commands. Has no sensory deficit that would limit ability to feel or communicate pain or discomfort.	4				
Moisture Degree to which skin is exposed to moisture	1. Constantly moist: Skin is kept moist almost constantly by perspiration, urine, drainage, etc. Dampness is detected every time patient is moved or turned.	2. Very moist: Skin is often, but not always, moist. Linen must be changed at least every 8 hours.	3. Occasionally moist: Skin is occasionally moist, requiring linen change every 12 hours.	4. Rarely moist: Skin is usually dry, routine diaper changes; linen only requires changing every 24 hours.	4				
FRICTION-SHEAR Friction Occurs when Skin moves against support surfaces Shear Occurs when skin and adjacent bony surface slide across one another	1. Significant problem: Spasticity, contracture, itching, or agitation leads to almost constant thrashing and friction.	2. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance.	3. Potential problem: Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relative good position in chair or bed most of the time but occasionally slides down.	4. No apparent problem: Able to completely lift patient during position change, moves in bed and in chair independently and has sufficient muscle strength to life up completely during move. Maintains good position in bed or chair at all times."	4				
Nutritional Usual food intake pattern	1. Very Poor: NPO/or maintained on clear liquids, or IVs for more than 5 days OR albumin < 2.5 mg/dl OR never eats a complete meal. Rarely eats more than half of any food offered. Protein intake includes only 2 servings or meat or dairy products per day. Takes fluids poorly. Does not take a liquid dietary supplement.	2. Inadequate: Is on liquid diet or tube feedings/TPN, which provides inadequate calories and minerals for age OR albumin < 3 mg/dl OR rarely eats a complete meal and generally eats only about half of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement.	3. Adequate: Is on tube feedings or TPN, which provide adequate calories and minerals for age OR eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered.	4. Excellent: Is on a normal diet providing adequate calories for age. For example, eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4				
Tissue Perfusion & Oxygenation	1. Extremely compromised: Hypotensive (MAP < 50 mm Hg; < 40 in a newborn) or the patient does not physiologically tolerate position changes.	2. Compromised: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be > 2 seconds; serum pH is < 7.40.	3. Adequate: Normotensive oxygen saturation may be < 95%; hemoglobin may be < 10 mg/dl; capillary refill may be 2 seconds; serum pH is normal.	4. Excellent: Normotensive, oxygen saturation > 95%; normal hgb; capillary refill < 2 seconds.	4				
TOTAL SCORE					28				
Evaluator's Name					Annab				

Severe Risk : less than 9 | High Risk : 10-12 | Moderate Risk : 13-14 | Mild Risk : 15-18 | Not at Risk: 19-23

Risk Score	Category	Action	Support Surfaces (Please Note: Only required for children who are deemed at risk due to altered mobility, consider occupation therapy referral for advice
15-18	At Risk	• Regular Turning Schedule • Enable as much activity as possible • Protect the heels • Use pressure redistribution surfaces • Manage moisture, friction and shear • Advance to a higher level of risk if other major risk factors are present	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
13-14	Moderate Risk	• Use the Same Protocol as for “At Risk” Patients • Position patient at 30 degree lateral incline using foam wedges	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
10-12	High Risk	• Follow the same protocol as for “Moderate Risk” Patients • In addition to regular turning schedule • Make small shifts in their position frequently	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay
Less than 9	Severe Risk	• Use same protocol as for “High Risk” Patients • Add a pressure redistribution surface for patients with severe pain or with additional risk factors.	High density foam mattress Gel pads for high-risk areas Alternating pressure mattress overlay



MULTI-DISCIPLINARY PLAN OF CARE FORM

Diagnosis: _____

Date Time	Discipline	Type	Patient Needs / Problem List	Goal	Plan / Intervention	Signature	Team Verification
11/7/22 Tun	☒ Medical ☐ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	oral Rehabilitation	Astable	NPO + VFR	[Signature]	☐ Nursing ☒ Others:
11/7/22 Tun	☐ Medical ☒ Nursing ☐ Others:	☒ Initial ☐ Modified ☐ Per-Op ☐ Post Op	Dental Care	Astable	NPO + VFR	Annab	☐ Medical ☒ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:
	☐ Medical ☐ Nursing ☐ Others:	☐ Initial ☐ Modified ☐ Per-Op ☐ Post Op					☐ Medical ☐ Nursing ☐ Others:

INTERDISCIPLINARY PATIENT / FAMILY EDUCATION RECORD

Part - I.

Patient's / Learner Language: English Patient / Learner Literacy: ☒ Read ☒ Write ☒ Speak Willingness to Learn: ☒ Yes ☐ No Healthcare Literacy: ☒ Yes ☐ No

Identified Education Needs:

- | | | | |
|----------------------------|--|--|---|
| 1. Diagnosis | 5. Medication / Therapy (safety, effects/ side effect, interactions) | 9. Nutrition / Diet | 13. Risk / Safety |
| 2. Treatment and Care Plan | 6. Discharge Medication | 10. Fall Risk Education | 14. Activity / Exercise |
| 3. Pain Management | 7. Infection Control Measures | 11. Safe use of Medical Equipment / Implantable Devices Safety | 15. Social & Rehabilitation Needs |
| 4. Informed Consent | 8. Diagnostic Test / Procedures | 12. Patient's / Family Rights | 16. Special Discharge / Follow-up Education / Coping Skills |
| | | | 17. Others |

Part - II

Date	Time	Need Identified	Information Taught	Use codes from the list in part III					Comments	Designation / Signature
				Person Taught	Learning Barriers	Teaching Tools	Mechanism/s to overcome barrier/s	Understanding		
11/7/26	7:20	10	fall Risk Education	mother	1	Oral	1	1	✓	MD

Part - III: CODES

Who was taught: PT: Patient F: Father M: Mother S: Spouse Sn: Son D: Daughter C: Caregiver O: Other (Specify)							
Learning Barriers: 1. No Learning Barriers 2. Physical Impairment 3. Emotional Barriers 4. Language Barrier 5. Educational Level 6. Desire / Motivate to Learn 7. Impaired Thought Process/Cognitive limitations 8. Responsibilities at Home 9. Cultural Differences 10. Financial Difficulties 11. Beliefs and Values 12. Impaired Vision/ or Hearing 13. Cultural/Religion Practice 14. Others (Specify)							
Teaching Tools Used: A: Audio D: Demonstration V: Video O: Oral P: Printed							
Mechanism/s to overcome barrier/s: 1. None 2. Obtain translator 3. Reassurance & Support 4. Teach Family / Others 5. Respect values & beliefs 6. Respect Cultural / Religion Preference 7. Other, Specify							
Understanding: 1. Verbalizes Understanding 2. Demonstrates Understanding 3. Needs Review							

BAH-00637118 IP5-00176243
Baby M SAI VIDHATHRI
29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO

ISENT FOR ANAESTHESIA

Authorization By: ☐ Patient ☒ Patient Attendant

Operative Procedure: Comprehensive Oral Rehabilitation

Anaesthesiologist: Dr. Subrahmanyam Surgeon: Dr. Namrata

Please read this before you consent for Anaesthesia

General anaesthesia involves rendering a patient unconscious before an operation. This ensures the patient is not aware of events and does not feel pain during the operation. Drugs given through a vein and / or inhaled from an anaesthesia machine produce it. Regional anaesthesia involves using a local anaesthetic to numb a specific area of the body for surgery: Prolonged pain relief can be achieved by infusing weak solutions of local anaesthetics and narcotic drugs to particular parts of the body after surgery or injury, using catheters.

Specific High Risk(s): The doctors have explained to me the details of the high risk involved due to the following medical problems and I have sought necessary clarification on all my doubts.

- ☐ Heart Disease ☐ Hypertension ☐ Diabetes ☐ Renal Failure ☐ Multi Organ Failure ☐ Hepatic Disorders
☐ Shock ☐ Obesity ☐ Chronic Obstructive Pulmonary Disease
☐ Others Bleeding, Laryngospasm

Declaration by Patient Attendant

- I authorize and give consent for anaesthesia as considered appropriate by the anaesthesia team
☐ Regional Anaesthesia ☒ General Anaesthesia ☐ Monitored Anaesthesia Care
- I understand that there are some infrequent complications that can occur due to use of anaesthesia, these include pain or some injury at the site of injections, temporary breathing difficulties, allergic reactions, headaches, variations in blood pressure, nausea and vomiting.
- I authorize the anaesthesia team to perform any additional procedures (for example, Central Venous Access, arterial line, use of suppositories and or nerve blocks for pain relief, changing from regional to general anaesthesia etc) which are considered necessary by them during the course of surgery.
- I also authorize and give consent to the team of doctors attending on me to administer blood products during the course of operative period and immediately thereafter if need arises.
- I acknowledge that the anaesthesiologist have informed me about the anaesthetic procedure, risk, benefits and alternative treatments.
- I acknowledge that I fully understand the above information. I have had the opportunity to ask questions, and they have been answered to my satisfaction in a language I understand. I affirm that this consent is given by me in my full senses.

Patient / Patient Attendant:

Signature: Hasika M

Name: Hasika M

Relationship with patient: Mother

Date & Time: 11/7/26 @ 7.30 AM

Witness:

Signature: Anna

Name: Anna

Date & Time: 11/7/26 7.30 AM

Doctor (who is taking consent):

Signature: B. de Name: Dr. Brunda Date: 9/7/26 Time: 5pm

అనస్థీషియా కోసం అనుమతి పత్రం

అనుమతి ఇచ్చినవారు: ☐ రోగి ☐ రోగి అటెండెంట్

శస్త్రచికిత్స:

అనస్థీషియా వైద్యుడు: శస్త్రచికిత్స నిపుణుడు:

అనస్థీషియా కోసం మీ అనుమతి ఇవ్వడానికి ముందు దయచేసి ఇది చదవండి

సాధారణ అనస్థీషియా అనేది శస్త్రచికిత్స ముందు రోగిని పూర్తిగా అపస్మారక స్థితిలోకి తీసుకెళ్లే ప్రక్రియ. దీనితో రోగి శస్త్రచికిత్స సమయంలో ఏదీ తెలుసుకోడు, నొప్పి అనుభవించడు. దీనిని శిరస్థావం ద్వారా ఇచ్చే మందులతో లేదా అనస్థీషియా యంత్రం నుండి పీల్చే మందులతో అందిస్తారు.

లిజనల్ అనస్థీషియా అనేది శరీరంలోని ఒక ప్రత్యేక భాగాన్ని లోకల్ అనస్థీషియా నొప్పి రాకుండా చేయడం. శస్త్రచికిత్స లేదా గాయం తరువాత దీర్ఘకాలిక నొప్పి ఉపశమనం కోసం, కాథెటర్లు ఉపయోగించి వీక్ లోకల్ అనస్థీషియా లేదా నార్మల్ బ్లడ్ మందులను నిరంతరం ఆ భాగానికి అందించవచ్చు.

స్పెసిఫిక్ హై రిస్క్:

క్రింద పేర్కొన్న వైద్య సమస్యల కారణంగా ఉండే అధిక ప్రమాదాల గురించి వైద్యులు నాకు వివరంగా చెప్పారు. నాకు ఉన్న సందేహాలను నేను అడిగాను మరియు అవి నివృత్తి చేయబడ్డాయి.

☐ హృదయ వ్యాధి ☐ రక్తపోటు ☐ మధుమేహం ☐ మూత్రపిండాల వైఫల్యం ☐ బహుళ అవయవ వైఫల్యం

☐ కాలేయ సమస్యలు ☐ షాక్ ☐ ఊబకాయం ☐ దీర్ఘకాల శ్వాసకోశ వ్యాధి (COPD)

☐ ఇతరవి:

రోగి / రోగి అటెండెంట్

- అనస్థీషియా బృందం అవసరమని భావించిన విధంగా నాకు అనస్థీషియా ఇవ్వడానికి నేను అనుమతి ఇస్తున్నాను.
☐ లిజనల్ అనస్థీషియా ☐ జనరల్ అనస్థీషియా ☐ మానిటర్డ్ అనస్థీషియా కేర్
- అనస్థీషియా ఉపయోగంలో అప్పుడప్పుడూ జరిగే కొన్ని అరుదైన సమస్యలు ఉండవచ్చు అని నేను అర్థం చేసుకున్నాను. వీటిలో ఇంజెక్షన్ ఇచ్చిన చోట నొప్పి లేదా స్వల్ప గాయం, తాత్కాలిక శ్వాస ఇబ్బందులు, అలెర్జిక్ ప్రతిచర్యలు, తలనొప్పి, రక్తపోటు మార్పులు, వాంతులు మరియు అసహనం వంటి సమస్యలు ఉండవచ్చు.
- శస్త్రచికిత్స సమయంలో అవసరం అనిపిస్తే, అదనపు చర్యలు (ఉదాహరణకు సెంట్రల్ వెన్స్ యాక్సెస్, ఆర్థిరియల్ లైన్, సపోజిటరీలు, నొప్పి నివారణ కోసం నర్వ్ బ్లాకులు, లిజనల్ అనస్థీషియా నుండి జనరల్ అనస్థీషియాకు మార్పు మొదలైనవి) చేయడానికి అనస్థీషియా బృందానికి నేను అనుమతి ఇస్తున్నాను.
- శస్త్రచికిత్స సమయంలో మరియు వెంటనే అనంతరం, అవసరమైతే రక్త పదార్థాలు (Blood products) ఇవ్వడానికి నా చికిత్సలో ఉన్న వైద్యుల బృందానికి కూడా నేను అనుమతి ఇస్తున్నాను.
- అనస్థీషియా విధానం, ప్రమాదాలు, ప్రయోజనాలు మరియు ప్రత్యామ్నాయ చికిత్సల గురించి అనస్థీషియా వైద్యులు నాకు వివరించినట్లు నేను అంగీకరిస్తున్నాను.
- పై సమాచారం అంతా నేను పూర్తిగా అర్థం చేసుకున్నాను. నాకు ప్రశ్నలు అడిగే అవకాశం లభించింది, మరియు నాకు అర్థమయ్యే భాషలో వాటికి సమాధానాలు ఇచ్చారు. ఈ అనుమతి నేను పూర్తిగా స్వచ్ఛమైన భావాలతో, స్వయంగా ఇస్తున్నానని ధృవీకరిస్తున్నాను.

రోగి / రోగి అటెండెంట్:

సంతకం:

పేరు:

రోగితో సంబంధం:

తేదీ & సమయం:

సాక్షి:

సంతకం:

పేరు:

తేదీ & సమయం:

డాక్టర్ :

సంతకం: పేరు: తేదీ & సమయం:

Department of Anaesthesiology
PRE-ANAESTHETIC EVALUATION

Name: Baby M Sai Vidhathi Age: 4y5m Sex: F UHID.No: BAH-00637118
Date: 9/7/26 Time: 5pm Proposed Operation: Comprehensive Oral Rehabilitation
Diagnosis: Dental Caries
B.P / CRT: _____ H.R: _____ Weight: 16kgs ASA Physical Status: ☒ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Laboratory Data:

Hgb: _____	Glucose: _____	Protein: _____	HIV: _____	X-Ray: _____
PCV: _____	Urea: _____	Alb: _____	HBS Ag: _____	ECG: _____
WBC: _____	Creat: _____	Total Bil: _____	HCV: _____	2D Echo: _____
Plate: _____	Na: _____	Dir. Bil: _____	Blood group: _____	Stress/Angio: _____
PT: _____	K: _____	LDH: _____	T3: _____	Other: _____
PTT: _____	Ca++: _____	Alk phos: _____	T4: _____	
INR: _____	Mg++: _____	Amylase: _____	TSH: _____	
	Cl-: _____	SGOT/SGPT: _____		

Allergies: NADA

Medical History: CVS: _____

PT, LSCS, Bwt: 3kgs, C/S, No ICU admissions.

RESP: No active / Recent URTI

Diabetes: _____

Development - (N) till date.

CNS: _____

Vaccinated till date.

Renal: _____

Hepatic / GE: _____

Physical Activity: Active.

Others: _____

Past Anaesthetic History: Nil.

Physical Exam:

Airway: MP 1 2 3 4 Mouth Opening: Adequate Mentohyoid Distance: (N) Neck: (N) Teeth: —

Lungs: Clear

Heart: S1S2

CNS: Child is active

Peripheral (N)

Pregnant: ☐ Yes ☒ No ☐ NA

Venous Access Site: accessible Spine Exam for regional: —

Anaesthetic Plan: ☐ MAC ☐ REGIONAL ☒ GA-ETT ☐ LMA

Peri-Operative Plan Explained to the Patient: ☒ Yes ☐ No

parents.

CURRENT MEDICATIONS	DOSAGE

Pre-Operative Instructions:

- DVT Prophylaxis: Water / ORS 2 Hours
- NIL ORAL Others 6 Hours Explained.
- Informed Consent: ☒ Standard ☐ High Risk
- Post Operative Pain Management: ☒ Discussed with Patient parents.
- Other Instructions: - CBP after cannulation

Signature: B. le Name: Dr. Brunda.



ANAESTHESIA CHART



Pre Induction Assessment:

Change in Patient Condition:	☐ Yes ☒ No	Fasting Status: <u>confirmed</u>
Physical Status:	☒ Patient Identified	☒ Consent Present
		☒ Chart Reviewed

H.R:	B.P / CRT:	SpO ₂ :	R.R:	Last Feed: <u>6 hrs</u>
Pre-OP Diagnosis: <u>Dental Caries</u>		Operation: <u>Comprehensive oral rehabilitation</u>		Date: <u>1/7/22</u>
Surgeon: <u>Dr. Namrata</u>		Anaesthesiologist: <u>Dr. Tejaswini</u>		Technician:

TIME	9:15	9:45	10:10	10:30	11
N ₂ O / AIR / O ₂ LPM	0.8 / 100 / 10	0.8 / 100 / 10	0.8 / 100 / 10	0.8 / 100 / 10	0.8 / 100 / 10
HALO / SO / SEVO	4.1	4.1	4.1	4.1	4.1
Drugs:					
MIDAZOLAM	0.8mg				
FENTANYL	30mcg				
PROPOFOL	30mg + 20mg				
ROCCURONIUM	8mg				
DEXAMETHASONE	11.5mg				
PARACETAMOL	240mg				
NEOSTIGMINE			0.5mg		
GALVOPYROLATE			160mcg		
FiO ₂ / SaO ₂	100 / 100	100 / 100	100 / 100	100 / 100	100 / 100
ETCO ₂	38	38	38	38	38
ECG	CR				
Temperature					
Urine Output					
Fluids					
Blood					
Antibiotic					
Suppository					
Blood Loss					
NOTES					

LAB Values	ABG				
	GRAB				
	Others				

☒ Equipment Checked and Functional ☐ BP ☒ Cuff Site: <u>RW</u> ☐ Art Site: ☒ EKG Lead ☒ Temp Site ☒ FIO ₂ Monitor ☒ Agent Monitor ☒ Pulse Oximeter ☒ Splanograph ☐ Ventilator ☐ Nerve Stimulator Position: <u>ROSE</u> ☒ Pressure Points Checked	Temp: ☒ HME ☐ Fluid Warmer ☐ Cling Film ☐ OH Warmer ☐ Hugger's ☐ Cotton Wool ☐ Other Times: Anaes Start: <u>9:20am</u> OP Start: <u>9:35am</u> OP End: <u>10:20am</u> Leave OR: <u>10:30am</u> Anaesthesia: ☒ GA ☐ Monitored Anaesthesia Care ☐ Regional Line (Size & Location) ☒ OP ☐ ART ☒ RW ☐ N ☐ IV	Induction ☒ IV ☐ Inhal ☐ Pre O ₂ ☐ RSI ☐ Others ☐ Mask ☐ SGA ☐ Airway ☐ Oral ☐ Nasal ETT# <u>4</u> at cm ☐ Oral ☐ Nasal ☐ Cuff ☐ Tracheostomy ☐ Topical ☒ Drug: <u>ROCCURONIUM</u> ☐ Awake ☐ Direct Vision ☐ Video Laryngoscopy ☐ Stylette / Bougie ☐ Fiberoptic Blade# <u>2</u> Attempts: <u>2</u> Difficulty Why? <u>Ant. Calypso</u> ☐ Bilat = BS ☐ Semi-Closed Circle ☒ Closed Circle ☐ Other	Regional: Extremity _____ Specify: _____ ☐ Spinal ☐ Epidural ☐ Caudal Others: _____ Position: _____ Site: _____ Needle Size: _____ Depth: _____ Parasthesia ☐ Yes ☐ No Catheter at skin cm Drug Name & Conc: _____ Bolus: _____ Infusion: _____ Block Level: _____ Comments: _____ Transportation to ☒ PACU ☐ ICU ☐ Other Relaxant Reversed ☒ Yes ☐ No ☐ NA Name of the Doctor: <u>Dr. Tejaswini</u> Signature of the Doctor: _____
--	--	--	--

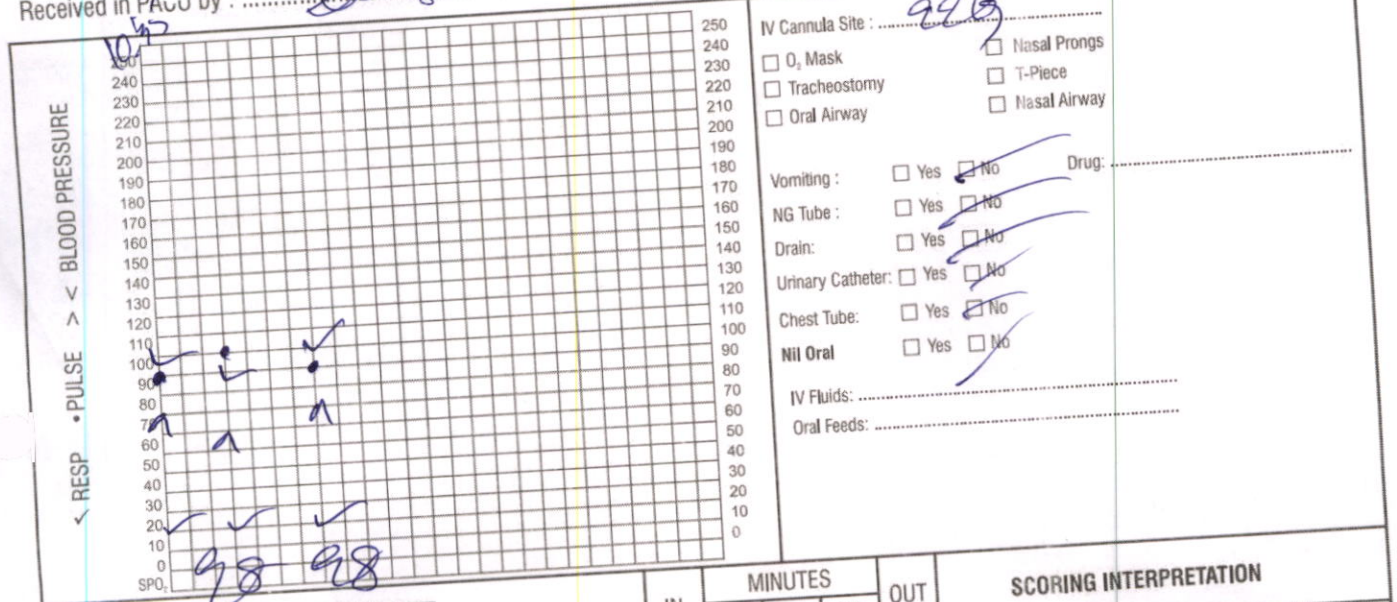
BAH-00637118 IP5-00176243
Baby M SAI VIDHATHRI
29-01-2022 4 Y 5 M 12 D (F)
Dr. NAMRATA KAMALAKAR RAO

POST-AN

CORD

Received in PACU by: *Dr. Anurag*

Time Received: *10:35 AM* Time Discharged: *11:30 AM*



IV Cannula Site: *99B*
☐ O₂ Mask ☐ Nasal Prongs
☐ Tracheostomy ☐ T-Piece
☐ Oral Airway ☐ Nasal Airway

Vomiting: ☐ Yes ☒ No
NG Tube: ☐ Yes ☒ No
Drain: ☐ Yes ☒ No
Urinary Catheter: ☐ Yes ☒ No
Chest Tube: ☐ Yes ☒ No
Nil Oral ☐ Yes ☒ No

IV Fluids: _____
Oral Feeds: _____

POST ANAESTHESIA SCORE (Modified Aldrete Score)			IN	MINUTES			OUT	SCORING INTERPRETATION
				30	60	90		
Able to move 4 extremities voluntary or on command	= 2	ACTIVITY	1	1	1	2		A Minimum Total Score of 8 is Required for Discharge Exceptions to this, are to be explained in the space below by the Discharging Physician:
Able to move 2 extremities voluntary or on command	= 1							
Able to move 0 extremities voluntary or on command	= 0							
Able to deep breathe & cough freely	= 2	RESPIRATION	2	2	2	2		
Dyspnea or limited breathing	= 1							
Apneic	= 0							
BP $\pm$ 20 of Pre Anaesthetic level	= 2	CIRCULATION	2	2	2	2		
BP $\pm$ 20-50 of Pre Anaesthetic level	= 1							
BP $\pm$ 50 of Pre Anaesthetic level	= 0							
Fully awake	= 2	CONSCIOUSNESS	1	1	2	2		
Arousable on calling	= 1							
Not responding	= 0							
Pink	= 2	COLOR	2	2	2	2		
Pale, dusky, blotchy, jaundiced, other	= 1							
Cyanotic	= 0							
TOTAL			8	8	9	10		

PAIN ASSESSMENT AND MANAGEMENT FORM

Date	Time	Pain Score	Intervention	Signature
11/7	10:35 PM	7/10		<i>Dr. Anurag</i>

Pain Tool Used: ☐ N PASS ☒ FLACC ☐ Wong Baker ☐ NPS

Anaesthesiologist Name: *Dr. Anurag*

Anaesthesiologist Signature: *[Signature]*

Date & Time: *11/7/2022 @ 11:30 AM*

PACU Nurse Name: *[Signature]*

PACU Nurse Signature: *[Signature]*

Date & Time: *11/7/2022 @ 11:30 AM*

Reassessment Frequency:

- Every eight hours for all hospitalized patients.
- For post surgical patient, patient with chronic pain, patient with severe pain
 - Every 2 hours for first 24 hours
 - After 24 hours every 4 hours
 - Prior to pain relieving intervention
 - With in 30-60 minutes after pain relief intervention

Transferred to Unit by (PACU): *Dr. Anurag*

Date & Time: *11/7/2022 @ 11:30 AM*

Date: Time: Procedure done by

CSE /Spi. Epidural Position : Space : Technique (LOR/LOS)

Depth: Catheter at Skin: Attempts :

Parasthesia : Yes/No if yes details :

Solution Composition :

Any other issues :

1)
2)

[illegible]

Delivery Details : Time : APGAR: SVD / Instrumental / LSCS (if LSCS Details)

Catheter Removed by and Tip Inspected : SVD / Instrumental / LSCS (if LSCS Details)

Patient Satisfaction :

Discharge /Shifting ordered by

Doctor Signature:

Doctor Name:

Date and Time: _____